

B-2. ACCIDENT REPORTING

I. SCOPE

These procedures are applicable to all employees of NCI-Frederick.

II. PURPOSE

- A. To provide for the systematic reporting and investigation of occupational injury and illness or work conditions that caused or reasonably could result in injury, illness, or property damage. Reporting is mandatory in order that:
1. Extent of injury or illness may be determined and appropriate interventions initiated.
 2. Cause(s) may be identified and, if appropriate, corrective action initiated to prevent a recurrence.
 3. OSHA reporting and recordkeeping requirements can be met.
 4. Workers compensation insurance notification requirements can be met.

III. DEFINITIONS

Accident - Is defined as an event occurring at work or while on company business that caused or reasonably could have caused injury or illness to personnel.

Occupational illness - Is defined as any abnormal condition or disorder, other than one resulting from an occupational injury, caused by exposure to environmental factors associated with employment. Occupational illnesses include acute and chronic illness or disease, which may be caused by inhalation, absorption, ingestion, injection, direct contact, or cumulative trauma.

Occupational injury - Is identified as any bodily damage such as a cut, fracture, sprain, strain, amputation, etc. which results from a single instantaneous exposure in the work environment.

IV. GENERAL PROCEDURES

- A. All accidents, regardless of apparent degree of severity or whether employees are injured or not, must be reported to the employee's supervisor and Occupational Health Services (OHS).
- B. EHS/OHS shall be responsible for notifying the Principal Investigator, SAIC-Frederick of all serious injuries or illnesses.
- C. Forms used:
 - 1. National Cancer Institute at Frederick Supervisor's Investigation of Injury/Illness, Exhibit B-2-1.
 - 2. "Workers Compensation - First Report of Injury or Illness", form IA-1 (5/93), Exhibit B-2-2.
 - 3. Accident investigation report generated by EHS.

V. RESPONSIBILITIES

- A. Supervisor
 - 1. Trains all employees in accident reporting requirements and reviews requirements annually with employees.
 - 2. Ensures that employees report each occupational illness and injury to EHS/OHS.
 - 3. Completes and submits the National Cancer Institute at Frederick Supervisor's Investigation of Injury/Illness form to EHS.
 - 4. Ensures that betadine scrubs are placed in a clearly visible area for emergency use.

B. Employees

1. Report each occupational injury or illness to their supervisor immediately and notify EHS if hazardous conditions exist as a result of the incident .
2. Perform appropriate first aid measures at the scene of the accident as necessary.
3. Report to OHS if injured or ill (regardless of severity).
4. Give statement to OHS staff. Sign the “employee statement” section of the National Cancer Institute at Frederick Supervisor’s Investigation of Injury/Illness form (Exhibit B-2-1).
5. Give signed National Cancer Institute at Frederick Supervisor’s Investigation of Injury/Illness form to supervisor.
6. Cooperate with EHS accident/injury investigation, if applicable.
7. Participate in initial safety training orientation sessions and periodic safety training as required.

C. Environment, Health and Safety Program (EHS)

1. Investigates all serious injuries and illnesses as soon as possible.
2. Reviews and investigates, as necessary, non-serious injuries and illnesses and potential exposures in accordance with internal SOPs and coordinates follow-up procedures with OHS.
3. Investigates causes to determine actions required to preclude recurrence.
4. Enters accident investigation information in the Occupational Health Manager (OHM) computer software system.
5. Maintains a permanent file of completed Supervisor’s Investigation of Injury/Illness forms (Exhibit B-2-1), and accident investigation reports.
6. Reports information on multiple injuries or death to OSHA officials as required by law.
7. Posts OSHA 200 Log.

D. Occupational Health Services

1. Injured employees or visitors will receive priority evaluation, treatment and follow-up by OHS staff.
2. Initial interview to determine nature of injury and potential for hazardous exposure. (Refer to OHS operations manual).
3. OHS staff will notify EHS of accidents requiring immediate EHS assistance, and coordinate care based on information derived from accident investigation.
4. In the event of serious injury, local community emergency response or referral procedures will be initiated. (Refer to B-1 Emergency Response Procedures.)
5. Completes and forwards to worker's compensation insurance carrier an Employer's First Report of Occupational Injury or Illness within 24 hours of first knowledge of an occupational injury or illness that requires medical treatment.
6. Maintains a copy of the first report of injury in the employee's medical record.
7. Updates the OSHA log regularly, regarding the number of days of lost time and restricted duty as required by 29 CFR 1904 and communicates this info as necessary.

National Cancer Institute at Frederick
Environment, Health and Safety Program
P.O. Box B, Building 426, Fort Detrick USAG
Frederick, Maryland 21702

Supervisor's Investigation of Injury/Illness

LOG CASE No: _____

EMPLOYEE, SAMPLE **123-45-6789**
Employee Name SSN Department Job Title
Company Employee's Supervisor Supervisor's Phone # Date & Time Reported to Supervisor
Bldg. _____
Loc. Of Accident (Be Specific) Date/Time Occurred Nature of Injury/Illness Specific Body Part

Witness

Employee's Statement(s):

"

"

Employee Signature	Date Signed
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Does your investigation concur with the employee's statement? List discrepancies and other missing information.

(use additional pages if necessary)

1. Was required personal protective equipment utilized? ☐ Yes ☐ No
2. Were safety rules violated? ☐ Yes ☐ No
3. Was discipline issued related to safety? ☐ Yes ☐ No To Whom? _____
4. Was use of power tool or machinery a factor in the injury? ☐ Yes ☐ No
If yes, identify: _____ Mfg Name: _____
5. Have there been similar injuries to other employees on the same job? ☐ Yes ☐ No
If yes, identify other employees by name and SSN: _____
6. Did employee return to his/her regular job? ☐ Yes ☐ No
7. Was employee temporarily transferred because of restriction assigned? ☐ Yes ☐ No
8. Was the employee unable to work because of lack of available and suitable work? ☐ Yes ☐ No

Action and preventive measures by supervisor to prevent recurrence of similar event:

(use additional pages if needed)

Is assistance needed from Maintenance or other departments to correct an unacceptable condition? ☐ Yes ☐ No
If yes, who was notified? _____ Dept _____
Date & Time _____

(COMPLETE REVERSE SIDE OF THIS FORM AS APPROPRIATE)

**UPON COMPLETION OF ALL APPLICABLE SECTIONS,
SIGN AND RETURN FORM TO EHS SECRETARY, BLDG. 426, ROOM 118**

NOISE:

1. Date assigned into high noise area: _____
2. Employee's current noise level exposure _____ dBA
3. Type of hearing protection worn: _____
4. Date of last employee training: _____
5. Are regular documented hearing protection audits of this department performed? ☐ Yes ☐ No
6. Has employee been wearing hearing protection properly? ☐ Yes ☐ No

TEMPERATURE/RADIATION:

1. Was cold temperature involved in illness? ☐ Yes ☐ No
2. Was illness related to heat stress? ☐ Yes ☐ No
If yes, was incident: ☐ Heat Stroke ☐ Heat Exhaustion
☐ Heat Rash ☐ Heat Cramps ☐ Other _____
3. What was heat stress index at time of incident? _____
4. What type of radiation was involved? ☐ Microwave ☐ Radio Frequency ☐ Ultra Violet
☐ Visible ☐ Lasers ☐ Beta, Gamma, X-Rays

REPETITIVE MOTION:

1. What body part was affected? _____
2. What was position of body part? _____
3. How often was position or action repeated each cycle? _____
4. How forceful was this action?(Light, Medium, Heavy) _____
5. Hours worked by employee per week _____
6. Current production or job rate per minute _____
7. Length of time on job causing condition? _____
8. Was vibrating tool used? ☐ Yes ☐ No
9. Was air temperature less than 50 F/10 C? ☐ Yes ☐ No

CHEMICAL:

1. Was chemical an approved material? ☐ Yes ☐ No
2. Part # _____ Supplier Code: _____
Description: _____ Chemical Name: _____
5. How long has employee used chemical? _____
6. Date last trained? _____ By Whom? _____
7. Were other chemicals involved? ☐ Yes ☐ No
8. List them: _____

BIOLOGICAL:

1. Exposure Type: _____
2. Exposure Fluid: _____
3. Exposure Route: _____
4. What procedure was involved? _____
5. When did exposure occur? _____
- 6a. Item Involved: _____ 6b. Item had a safety design? ☐ Yes ☐ No
7. Was the item contaminated? _____
8. What was the item's original purpose? _____

Supervisor's Name (Please Print): _____
I.D.No. _____

Supervisor's Signature: _____ Date _____

WORKERS COMPENSATION - FIRST REPORT OF INJURY OR ILLNESS

G E N E R A L	EMPLOYER (NAME & ADDRESS INCL ZIP)				CARRIER/ADMINISTRATOR CLAIM NUMBER				REPORT PURPOSE CODE							
	SAIC-Frederick, Inc. P.O. Box B Frederick MD 21702				JURISDICTION				JURISDICTION CLAIM NUMBER							
					INSURED REPORT NUMBER											
	SIC CODE				EMPLOYER FEIN				EMPLOYER'S LOCATION ADDRESS (IF DIFFERENT)				LOCATION #			
												PHONE #				
C L A I M S A D M I N	CARRIER (NAME, ADDRESS & PHONE NO)				POLICY PERIOD				CLAIMS ADMINISTRATOR (NAME, ADDRESS & PHONE NO)							
													CHECK IF APPROPRIATE			
					SELF INSURANCE											
	CARRIER FEIN				POLICY/SELF-INSURED NUMBER				ADMINISTRATOR FEIN							
AGENT NAME & CODE NUMBER																
E M P L O Y E E	NAME (LAST, FIRST, MIDDLE)				DATE OF BIRTH		SOCIAL SECURITY NUMBER				DATE HIRED		STATE OF HIRE			
	ADDRESS (INCL ZIP)				SEX		MARITAL STATUS				OCCUPATION/JOB TITLE					
	TELEPHONE (INCLUDE AREA CODE)				MALE		UNMARRIED				EMPLOYMENT STATUS					
					FEMALE		SINGLE/DIVORCED									
				UNKNOWN		MARRIED										
						SEPARATED										
						UNKNOWN				NCCI CLASS CODE						
W A G E	RATE		PER:		DAY		MONTH		# DAYS WORKED/WEEK		FULL PAY FOR DAY OF INJURY?		YES		NO	
					WEEK		OTHER:				DID SALARY CONTINUE?		YES		NO	
O C C U R R E N C E	TIME EMPLOYEE BEGAN WORK		AM		DATE OF INJURY/ILLNESS		TIME OF OCCURRENCE		AM		LAST WORK DATE		DATE EMPLOYER NOTIFIED		DATE DISABILITY BEGAN	
			PM						PM							
	CONTACT NAME/PHONE NUMBER						TYPE OF INJURY/ILLNESS						PART OF BODY AFFECTED			
	DID INJURY/ ILLNESS EXPOSURE OCCUR ON EMPLOYER'S PREMISES?						TYPE OF INJURY/ILLNESS CODE						PART OF BODY AFFECTED CODE			
	<input type="checkbox"/> YES <input type="checkbox"/> NO															
	DEPARTMENT OR LOCATION WHERE ACCIDENT OR ILLNESS EXPOSURE OCCURRED						ALL EQUIPMENT, MATERIALS, OR CHEMICALS EMPLOYEE WAS USING WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED									
	SPECIFIC ACTIVITY THE EMPLOYEE WAS ENGAGED IN WHEN THE ACCIDENT OR ILLNESS EXPOSURE OCCURRED						WORK PROCESS THE EMPLOYEE WAS ENGAGED IN WHEN ACCIDENT OR ILLNESS EXPOSURE OCCURRED									
	HOW INJURY OR ILLNESS/ABNORMAL HEALTH CONDITION OCCURRED. DESCRIBE THE SEQUENCE OF EVENTS AND INCLUDE ANY OBJECTS OR SUBSTANCES THAT DIRECTLY INJURED THE EMPLOYEE OR MADE THE EMPLOYEE ILL														CAUSE OF INJURY CODE	
DATE RETURN(ED) TO WORK				IF FATAL, GIVE DATE OF DEATH				WERE SAFEGUARDS OR SAFETY EQUIPMENT PROVIDED?				YES		NO		
								WERE THEY USED?				YES		NO		
T R E A T M E N T	PHYSICIAN/HEALTH CARE PROVIDER (NAME & ADDRESS)						HOSPITAL (NAME & ADDRESS)						INITIAL TREATMENT			
													<input type="checkbox"/> NO MEDICAL TREATMENT <input type="checkbox"/> MINOR: BY EMPLOYER <input type="checkbox"/> MINOR CLINIC/HOSP <input type="checkbox"/> EMERGENCY CARE <input type="checkbox"/> HOSPITALIZED>24 HRS <input type="checkbox"/> FUTURE MAJOR MEDICAL /LOST TIME ANTICIPATED			
O T H E R	WITNESSES (NAME & PHONE #)															
	DATE ADMINISTRATOR NOTIFIED				DATE PREPARED				PREPARER'S NAME & TITLE				PHONE NUMBER			

FORM IA-1 (5/93)

SEE BACK FOR IMPORTANT INFORMATION/OSHA REQUIREMENTS

IAIABC 1993
WC/FR 1

NOTICE

This form is NOT a claim for compensation. Failure to file a claim within 2 years of the date of accidental injury may bar an employee's claim for compensation. Employees may obtain claim forms from the Workers' Compensation Commission.

EMPLOYER:

COMPLETE BOTH SIDES OF THIS FORM AND SEND IT IMMEDIATELY --

WORKERS' COMPENSATION COMMISSION 6 NORTH LIBERTY STREET, BALTIMORE, MARYLAND 21201-3785

A copy of this form must be mailed to the DIVISION OF LABOR AND INDUSTRY, 501 ST. PAUL PLACE, BALTIMORE, MARYLAND 21202 and an additional copy should be sent by the employer to his or her workers' compensation insurance carrier. The weekly earnings schedule below of the employee whose injury is being reported on the front side of this form should be completed at the time the report is submitted if at all possible, but in any event the wage information must be supplied no later than ten (10) days following the the employer's receipt of a Notice of Claim from the Commission. An employer's failure to submit the wage information as required will result in the Commission's use of information supplied by the Claimant to the possible detriment of the employer.

REPORT OF WAGE INFORMATION

MILDRED R FLEMMING

216-54-4915

Injured Employee Name

Social Security Number

Week No.	Week Ending			GROSS	Amount Paid Including all Overtime
	Month	Day	Year		
1				0	0.00
2				0	0.00
3				0	0.00
4				0	0.00
5				0	0.00
6				0	0.00
7				0	0.00
8				0	0.00
9				0	0.00
10				0	0.00
11				0	0.00
12				0	0.00
13				0	0.00

Was this employee given free rent, lodging, board, tips or other allowances in addition to the above earnings? If yes, state weekly value thereof. \$ _____

Signed _____